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Young people, partner abuse and sexual health: indicators of increased risk

Abstract

Partner abuse (PA) is common amongst young people, but is often missed by health, social care and education professionals, as well as the criminal justice system. This paper explores the types of PA experienced by young people and links with sexual health to see whether there are factors which indicate vulnerability to abuse. Young people aged 16 to 20 from across the UK (n=1,754) completed an online survey in 2010-11. We report experience of emotional, physical and sexual partner abuse and model the associations with demographic and sexual health variables in bivariate analysis using logistic regression. A third of participants reported one or more types of partner abuse within the previous three months, regardless of gender of partner. PA was significantly associated with sexually transmitted infection (Odds Ratios 1.6 and 2.9 for young women and young men respectively), regretted sex (OR 2.7 and 1.9), distress or worry about sex life (OR 2.5 and 4.6), sexual problems, numbers of sexual partners (OR 1.2 for each additional partner), and sexual health service use (for young men) (OR=1.9). These *indicators* may be noticed by professionals who work with young people, and can prompt them to ask about partner abuse.

INTRODUCTION

Partner abuse (PA) refers to controlling, coercive or threatening behaviour, violence or abuse from an intimate partner regardless of gender or sexuality, and includes emotional, physical and sexual abuse, and control of freedom and resources. Partner abuse is a global, gendered problem (Heise and Kotsadam 2015). It affects men as well as women, although women suffer more sexual abuse, more severe physical abuse, and more coercive control than men (Feder and Howarth 2014). The lifetime prevalence of partner abuse internationally ranges from 15% to 71% (Garcia-Moreno et al. 2006). In England and Wales, an estimated 6.5% of women and 2.8% of men aged 16 to 59 experienced partner abuse in 2016, with a lifetime prevalence of 28.3% and 14.7% respectively (Office for National Statistics 2017).

Partner abuse also occurs in young people's relationships, at higher rates than for older age groups. Women aged 16 to 19 were more likely than older age groups to experience domestic abuse (13.1% compared with 6.8% overall), (Office for National Statistics 2015) and the same is true for young men (7.5% compared with 3.0%). Young women were also more likely to be victims of sexual abuse and stalking compared with older age groups (Office for National Statistics 2015). For many young women, their first sexual experience is coerced: 17% of women in Tanzania, 24% of women in Peru, and 30% of women in Bangladesh reported their first sexual experience as forced (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts 2006). PA is the second most common risk factor for disability adjusted life years globally in women aged 20 to 24 years (Mokdad et al. 2016).

A UK school survey found that 72% of girls and 51% of boys aged 13 to 17 had been subject to emotional violence from a partner. Twenty-five percent of girls and 18% of boys had suffered physical violence, and 31% of girls and 16% of boys had suffered sexual violence (Barter et al.

2009). In the National survey of Sexual Attitudes and Lifestyles (NATSAL-3), 6.9% of young women and 0.8% of young men aged 16 to 24 reported non-consenting sex (ever) (Macdowall et al. 2013). Intimate partner violence is therefore more commonly experienced by girls than by boys, but is also more often ongoing, and has a greater negative impact on girls' wellbeing (e.g. feeling frightened or upset).(Barter, McCarry, Berridge, & Evans 2009)

Intimate partner violence damages health (Trevillion et al. 2012). Women who experience intimate partner violence are at greater risk of chronic health conditions, including gynaecological problems, gastrointestinal disorders, neurological symptoms, chronic pain, cardiovascular conditions and mental health problems (particularly post-traumatic stress disorder, depression, anxiety, suicidal thoughts, and substance misuse) (Ellsberg et al. 2008;Feder et al.;Macdowall, Gibson, Tanton, Mercer, Lewis, Clifton, Field, Datta, Mitchell, Sonnenberg, Erens, Copas, Phelps, Prah, Johnson, & Wellings 2013). The prevalence of domestic violence (including partner abuse) is high in primary care populations and amongst those who present to sexual health services, for example women seeking abortion (Macdowall, Gibson, Tanton, Mercer, Lewis, Clifton, Field, Datta, Mitchell, Sonnenberg, Erens, Copas, Phelps, Prah, Johnson, & Wellings 2013) and women who are pregnant under 18 (Macdowall, Gibson, Tanton, Mercer, Lewis, Clifton, Field, Datta, Mitchell, Sonnenberg, Erens, Copas, Phelps, Prah, Johnson, & Wellings 2013). PA is associated with adverse sexual health outcomes including sexually transmitted infection, vaginal discharge, chronic pelvic pain, sexual risk-taking, inconsistent condom use and sexual dysfunction (Coker 2007;Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno 2008).

Although partner abuse is so common, health and social care professionals may not be aware of it. For example, most women are not asked about abuse in health care settings, despite the clear links between abuse and ill-health.(Feder et al. 2011) Young people may be reluctant to disclose

partner abuse to adults. For example, only 8% of girls and 7% of boys told a parent or carer about physical violence, and 3% of girls and 5% of boys told another adult.(Barter, McCarry, Berridge, & Evans 2009).

In this paper we report the findings of a web-based sexual health survey of 1,754 young people living in the United Kingdom. We report in detail the type of partner abuse (PA) experienced by young women and men, and explore links with sexual health to see which factors might indicate increased vulnerability..

METHODS

Design and setting

This study is a cross-sectional survey of 1,754 young people aged 16 to 20, recruited mainly online. . The survey comprised sexual health outcome questions which were asked at baseline in an online randomised controlled trial of the Sexunzipped website (Bailey et al. 2013) (*see Appendix – sexual health questionnaire*). For this study of partner abuse, we analysed the baseline responses of all trial participants (prior to randomisation), treating the data as a non-randomly selected cross-sectional survey. The study was approved by the University College London ethical committee (reference 1023/002).

Participant recruitment

We advertised the study on sexual health websites and Facebook, sent an advert to schools and colleges, and invited participants to tell friends.(Bailey, Pavlou, Copas, McCarthy, Carswell, Rait, Hart, Nazareth, Free, French, & Murray 2013). The advertisement featured the Sexunzipped logo and asked, ‘*Interested in sexual health? Willing to help us with our research?*’ The study focused on many dimensions of sexual wellbeing, and was not specifically about intimate partner abuse. Eligible participants (young people 16 to 20 years old, resident in the United Kingdom) enrolled online through the Sexunzipped trial website, submitting consent online and completing

a baseline questionnaire before randomisation. The online trial system automatically assigned code numbers to participants to preserve their anonymity, and we stored data securely on encrypted drives.

Outcome measurement

The Sexunzipped online questionnaire featured items from validated sexual health outcome measurement instruments including indicators for AIDS prevention programs,(UNAIDS 2009) the National Survey of Sexual Attitudes and Lifestyles,(Wellings et al. 2001) and the HARK four-question scale to assess intimate partner abuse.(Sohal et al. 2007) The questionnaire solicited demographic information and sexual health outcomes including mediators of sexual behaviour change (sexual health knowledge, self-efficacy, and safer sex intention), sexual behaviour (condom and contraception use, use of services, and partner numbers), self-reported sexually transmitted infections, pregnancy, sexual problems, partner abuse, regretted sex, sexual pleasure, and relationship and sexual satisfaction (*see Appendix: sexual health questionnaire*).(Bailey, Pavlou, Copas, McCarthy, Carswell, Rait, Hart, Nazareth, Free, French, & Murray 2013)

We asked six questions concerning partner abuse (see Box 1). Four questions were derived from the HARK abuse assessment tool (Pathak et al. 2017;Sohal, Eldridge, & Feder 2007). We adapted the wording of the third HARK question to omit the term ‘raped’ in the light of feedback from young people during qualitative field testing of the questions. Data were collected between November 2010 and March 2011.

Box 1. HERE - Partner abuse questions

Data analysis

We estimated proportions of young people experiencing emotional, sexual and physical abuse, and the associations with demographic and sexual health variables. A positive response to one or more of the HARK questions was taken to indicate PA. HARK 1 or 2 or Additional Question 1 were considered ‘emotional abuse’; HARK 3 or Additional Question 2 were considered ‘sexual abuse’; and HARK 4 was considered ‘physical abuse’. We used bivariate logistic regression to model the associations of demographic and sexual health variables with partner abuse. We restricted this analysis to participants reporting opposite gender sexual partners (F-M and M-F) because of the small numbers of men with male partners (n=117), women with female partners (n=41), men with both gender partners (n=67), women with both gender partners (n=73), and transgender or other gendered people (n=12). Statistical analyses were conducted using STATA Version 12 (StataCorp LP, Texas, USA).

RESULTS

Participant recruitment

There were almost three million UK Facebook users aged 18-20 in 2010 (Inside Network 2012) but we do not know how many actually saw the advertisement or heard about the study via other routes. An estimated 6,710 people viewed the Sexunzipped study website: 4,931 of these met the eligibility criteria for age and UK residence and 2,036 of those (41%) submitted questionnaire data. Most participants were recruited via Facebook (84%), with others via friends or relatives (9%), email (4%), and through school or college (2%).(Bailey, Pavlou, Copas, McCarthy, Carswell, Rait, Hart, Nazareth, Free, French, & Murray 2013)

Participant identity verification and data cleaning

Eighteen participants withdrew, and twelve registered more than once so were removed from the data set. Sixty six participants who gave inconsistent answers to sexual health questions were removed, and we also excluded 119 participants who were not in sexual relationships in the last three months and 108 who had never had (genital) sex, since self-reported STI was a principal

outcome of interest. Twenty three people whose own or partners' gender was transgender or 'other', could not be included, since the numbers were too small to do meaningful analyses. We analysed data from the remaining 1,754 participants.

Participants

Two thirds of participants were female (1129/1754). Participants ranged in age from 16 to 20 with a median age of 19 years, recruited from across the UK.(Bailey, Pavlou, Copas, McCarthy, Carswell, Rait, Hart, Nazareth, Free, French, & Murray 2013) Ninety percent of participants were White (British, Irish, European or other); 2.2% Black (British, Caribbean, African or other); 2.2% Asian (British, Chinese, Pakistani, Indian or other); 3.3% of mixed cultural background; and 0.1% 'other'. Most (79%) were still in education. Most sexual partnerships within the last 3 months were with opposite-gender partners (Table 1), and most young people reported being in a relationship with one person (*see Appendix - Supplementary data*).

Partner abuse by gender and gender of partner/s

A third of all participants reported one or more types of partner abuse within the previous three months, regardless of gender of partner (31% of young women (n=347/1129) and 35% of young men (n=217/625)). Emotional abuse and control were the most common forms of abuse reported by both male and female participants, with 10% to 37% reporting this over the last three months (Table 1).

Table 1 HERE - Partner abuse by gender and gender of partner/s

Young people commonly experienced more than one type of abuse. Emotional abuse was reported by 26% of young women with male partners (n=1019), with 12% reporting sexual abuse or pressure and 7% physical abuse in the previous three months. The proportions of types of abuse were similar for young men with female partners (n=441) (see Figures 1 and 2).

Figure 1. HERE - Young women with male partners: type of partner abuse in previous 3 months (n=1019)

Figure 2. HERE - Young men with female partners: type of partner abuse in previous 3 months (n=441)

Factors associated with partner abuse – young women with male partners

Factors associated with increased PA

There were significant associations of PA with regretted sex (OR 2.7; 95% CI 2.0 to 3.6); 1-5 episodes of unprotected anal sex (OR 1.7; 95% CI 1.1 to 2.6), self-reported STI (OR 1.6; 95% CI 1.1 to 2.5), lack of interest in sex (OR 1.7; 95% CI 1.3 to 2.3; vaginal dryness (OR 1.8; 95% CI 1.3 to 2.4); difficulty with orgasm (OR 1.8; 95% CI 1.3 to 2.6); distress or worry about sex life (OR 2.7; 95% CI 1.9 to 3.9), and greater numbers of male sexual partners in the last three months (Table 2).

Protective factors

There were significantly reduced proportions of PA over the previous three months in women who were not White (OR 0.6; 95% CI 0.4 to 0.9), women still in education (OR 0.7; 95% CI 0.5 to 1.0), and those in a relationship with one person (OR 0.5; 95% CI 0.4 to 0.7). We also found significantly reduced proportions of PA for women reporting greater emotional or physical pleasure at last sex (OR 0.4; 95% CI 0.3 to 0.6), (OR 0.5; 95% CI 0.4 to 0.7); greater satisfaction

with relationships (OR 0.4; 95% CI 0.3 to 0.6); satisfaction with their sex lives (OR 0.5; 95% CI 0.4 to 0.8), and higher levels of safer sex communication self-efficacy (OR 0.4; 95% CI 0.3 to 0.6) (Table 2). There were no associations of partner abuse with unprotected vaginal sex, being too drunk or high to remember sex, use of any form of contraception, or use of sexual health services.

Table 2. HERE - Associations with partner abuse (≥ 1 HARK questions) – women with male partners

Factors associated with partner abuse – young men with female partners

Factors associated with increased PA

Young men with female partners who were not White were more likely to report PA (OR 2.1; 95% CI 1.1 to 3.8). We also found significant associations of PA with regretted sex (OR 1.9; 95% CI 1.1 to 3.2); self-reported sexually transmitted infection (OR 2.9; 95% CI 1.4 to 6.1); use of sexual health services (OR 1.9; 95% CI 1.1 to 3.2); lack interest in sex (OR 1.8; 95% CI 1.1 to 3.1); anxiety during sex (OR 1.0; 95% CI 1.0 to 1.0); distress or worry about sex life (OR 4.6; 95% CI 2.5 to 8.2), and greater numbers of female sexual partners in the last three months (Table 3).

Protective factors

Men reporting greater physical pleasure at last sex (OR 0.5; 95% CI 0.3 to 0.9); and greater satisfaction with their relationships (OR 0.3; 95% CI 0.1 - 0.5) and satisfaction with their sex lives (OR 0.4; 95% CI 0.2 - 0.7) were less likely to have experienced PA (Table 3). For men, there were no associations between PA and still being in education, levels of self-efficacy, being too drunk or high to remember sex, or unprotected anal or vaginal sex (Table 3).

Table 3. HERE - Associations with partner abuse (≥ 1 HARK questions) – men with female partners

Partner abuse and regretted sex or distress or worry about sex life

Regretted sex, and distress or worry about sex life were associated with PA for both men and women, so we tested whether these variables might be useful as ‘indicator’ questions to help detect partner abuse by health professionals, combining data from both male and female respondents.

The proportion of those who regretted sex who had also experienced recent PA in the previous three months was 207/611 (positive predictive value 34%). The proportion of those who had not regretted sex who had not experienced PA was 950/1143 (negative predictive value 83%).

The proportion of those who were distressed or worried about their sex lives who had also experienced PA in the previous three months was 130/344 (positive predictive value 38%). The proportion of those who were not distressed or worried and who had not experienced PA was 1140/1410 (negative predictive value 81%).

DISCUSSION

Partner abuse was common in this population of young people who were recruited online, with emotional abuse and control the most common forms of abuse. PA is associated with a cluster of negative sexual health outcomes for young people with opposite gender partners. We found significant associations with regretted sex; sexual problems; reduced satisfaction with relationships and sex life; distress or worry about sex life; and reduced pleasure at last sex. PA was also associated with greater numbers of sexual partners in the last three months, unprotected

anal sex (for women), and self-reported sexually transmitted infection. More than a third of those who had regretted sex recently, or who felt distressed or worried about their sex lives had experienced PA.

We recruited a large number of young people from all four countries of the UK, but since participants in this study were not randomly selected, we cannot make inferences about the national prevalence of PA. Soliciting data online facilitates honesty,(Copas et al. 2002;Nicholas et al. 2013) and the high internal consistency of responses demonstrates good data validity. The associations with predictive variables are robust and provide insight into clusters of harms which are associated with PA. Sample sizes were not large enough to explore links with sexual health for young people in same-gender relationships.

The study may have attracted young people who particularly wished to report their sexual health experiences (either positively or negatively). Two thirds of the participants were female and 90% them had opposite gender partners (F-M =1019/1129), so the precision of the analysis of these women's responses was greater than for the other groups. There are inherent imprecisions in analyses of survey data.(Potter 2001) Abuse may be under-reported for many reasons including fear of the consequences,(Andersson et al. 2010) not identifying with terms used to describe abuse (Evans et al. 2015) or perceiving it as normal (Barter 2015). . There are substantial gender differences in the experience of PA, over and above differences in prevalence (Barter, McCarry, Berridge, & Evans 2009;Brennan 2009;Hester 2013), but we did not measure intent, severity, frequency and impacts of PA (other than STIs).(Myhill 2017) The cross-sectional nature of our data does not allow conclusions about causal pathways, and we did not conduct multi-variate analyses since clusters of adverse sexual health outcomes are linked with abuse in complex ways (Andersson, Cockcroft, Ansari, Omer, Ansari, Khan, & Chaudhry 2010).

Other studies have found that abuse was more commonly reported by young women than young men,(Barter, McCarry, Berridge, & Evans 2009) and seems to be more frequent in young people who have sexual partners of both genders (Finneran and Stephenson 2013;Macdowall, Gibson, Tanton, Mercer, Lewis, Clifton, Field, Datta, Mitchell, Sonnenberg, Erens, Copas, Phelps, Prah, Johnson, & Wellings 2013;Mercer et al. 2007;Pathela and Schillinger 2010). The UK NATSAL-3 found associations between non-consenting sex and more lifetime sexual partners, STI, and low sexual function in both men and women (Macdowall, Gibson, Tanton, Mercer, Lewis, Clifton, Field, Datta, Mitchell, Sonnenberg, Erens, Copas, Phelps, Prah, Johnson, & Wellings 2013) and PA was also associated with acquisition of HIV (Li et al. 2014). We found associations between PA and with unprotected anal sex in young women, but not with unprotected vaginal sex. Other studies describe links between PA and partner refusal to use a condom or not permitting women to use contraception (Fair and Vanyur 2011). Sexual pressure and control of freedom is common amongst young women and young men (Barter 2015). The ubiquitous use of technology such as mobile phones and social networking sites provide avenues for abuse which particularly affect young people, and there are strong links between online abuse and physical abuse (Barter 2015).

Young people may be reluctant to disclose partner abuse to anyone, especially adults (Barter, McCarry, Berridge, & Evans 2009). Healthcare services may be the only point of contact with professionals and there is polling evidence in England and Wales that children aged 11 to 17 have greater trust in doctors than in any other group of adults (Ipsos MORI 2017). Adult women would like health care professionals to provide support (Feder, Davies, Baird, Dunne, Eldridge, Griffiths, Gregory, Howell, Johnson, Ramsay, Rutterford, & Sharp), to be non-judgmental and nondirective, and to appreciate the complexity of partner violence (Feder et al. 2006) and men are also willing to being asked about abuse and violence in a health service setting (Morgan et al.

2014). We found an association between PA and use of sexual health services for young men (although men generally consult health services less frequently than women).

There are screening tools available to increase detection of abuse, but no evidence that screening and detection alone reduces future occurrence or the impact of abuse (O'Doherty et al. 2014). An effective alternative approach in health care contexts is to ask about the abuse in relation to symptoms and conditions that are associated with abuse, such as anxiety, depression, chronic pain, non-specific symptoms, and – after disclosure - to offer to refer on to specialist advocacy services.(Feder, Davies, Baird, Dunne, Eldridge, Griffiths, Gregory, Howell, Johnson, Ramsay, Rutterford, & Sharp) There are a cluster of adverse sexual health outcomes associated with PA which may be symptoms (e.g. STI or sexual problems), or factors which may emerge in a sexual history (e.g. larger numbers of sexual partners, regretted sex, distress or worry about sex life). It is essential that disclosure is in patients' best interests, and will not lead to harms such as breaches of confidentiality and escalation of risk.(Feder, Hutson, Ramsay, & Taket 2006;Pathak, Sohal, & Feder 2017) Clear pathways for referral are vital (Pathak, Sohal, & Feder 2017). Improvement in the health care response to PA among young people and adults of any age needs to focus less on how people experiencing PA are identified and more on how to support them after disclosure (Feder 2016).

CONCLUSIONS

Partner abuse is experienced by young women and young men, and is associated with a cluster of negative sexual health outcomes including sexually transmitted infections, higher numbers of sexual partners, sexual problems, regretted sex, and distress or worry about sex lives.

These *indicators* may be noticed by professionals who work with young people in a variety of settings including health and social care, education, youth work, and the criminal justice system, and should be prompts to ask about partner abuse.

Key Messages

- Emotional abuse and control were the most common forms of abuse reported by by young people
- Young people with greater numbers of sexual partners, sexually transmitted infection or sexual problems are more likely to suffer partner abuse
- More than a third of those who had regretted sex, or who felt distressed or worried about their sex lives had experienced partner abuse

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Contribution of authors

LT conducted a background literature search. JB and GF designed the survey questions. MP and AC conducted statistical analyses. All authors interpreted data. JB wrote the first draft and all authors contributed to revisions of the submitted paper.